Name: _____ Social Security Number:_____

Address: _____

_____

City, State, Zip: _____

Dear Applicant:

In an effort to continually improve our services to Social Security disability claimants, the Division of Disability Determination Services is surveying claimants' as to their satisfaction regarding consultative examinations. This information is confidential and is utilized solely by our agency in order to improve the quality of service we provide. Please complete and return the enclosed form within five (5) days. For your convenience we have enclosed a postage paid return envelope.

This consultative examination is being performed to help us determine your eligibility for Social Security disability. Based on information in your file; DDS medical/adjudicative staff determine what tests and x-rays are to be performed. The report the consultative examination doctor submits to our agency is not the sole basis for the decision on your claim.

Please note; the consultative examiner can not provide you with any medical treatment.
This form is not to be completed by the doctor or you in his/her presence

Sincerely
Medical Relations Specialist

Consulting Examiner: _____
Address:
City, State, Zip:
Specialty:

Appointment date: _____ Time: _____

1. Did the doctor or his/her staff ask for your insurance (BC/BS, Medicare, and Medicaid) number?
Yes ___ No ____

Circle the appropriate rating and give a written explanation for any item that you wish to comment on, on the back of this questionnaire.

2. Professionalism of office staff? Poor Fair Good Very Good Outstanding
(answer only if there was any staff)
3. Professionalism of doctor? Poor Fair Good Very Good Outstanding
4. Cleanliness of facility? Poor Fair Good Very Good Outstanding
5. Privacy provided? Poor Fair Good Very Good Outstanding
6. Completeness of examination? Poor Fair Good Very Good Outstanding
7. Timeliness you were examined? Poor Fair Good Very Good Outstanding
8. Other Comments (Please put on the back of this form)

_____ _____
Signature Date

RETURN FORM TO: Division of Disability Determination Services
P.O. Box 649
Newark, New Jersey 07101
ATTENTION: Nancy Hendricks

C-202 (2/02)